ARTICLE 4

SECTION 2

APPLICATION PROCESSING REQUIREMENTS

1. GENERAL INFORMATION

This section establishes procedures for processing an application for Medi-Cal. Clarifications regarding who may apply, completion of the Statement of Facts, determination of eligibility and applicant/beneficiary responsibilities are provided in this section. The content of the Basic Packet is the same for all applications. See MPG 4-2-14 for the forms required to be in both the Basic Packet and the Supplemental Packet.

2. APPLICATION PROCEDURES

A. Form SAWS 1

MEM 50159
MEM 50161

The SAWS 1 is not required with the new MC 210 (8/01). An application using the new MC 210 (8/01) cannot be denied on the basis that there is not a SAWS 1, or that the SAWS 1 is incomplete. However, DHS has indicated that counties may continue to use the SAWS 1 with the new MC 210 to establish the date of application, even though the SAWS 1 is not **required** for Medi-Cal eligibility.

If an individual is unable to apply on his/her own behalf, or is deceased, a SAWS 1 may be filed by any of the following persons:

1) The applicant's guardian, conservator or executor;

2) A person who knows of the applicant's need to apply; or

3) A public agency representative.

NOTE: If the application is made by someone other than the applicant, or by a County worker on the applicant's behalf, the application MUST be countersigned by the applicant at the first opportunity, unless the applicant is deceased, mentally incompetent, or physically incapable of signing. THE SAWS 1 IS SIGNED UNDER PENALTY OF PERJURY.

MEM PROC. 4I

B. Establishing the Date of Application

1) If an MC 210 (8/01) is mailed directly to the county, the date of application is the date the county receives the form.

MEM 50159
MEM 50161

2) If the MC 210 (8/01) is picked up at a Family Resource Center (FRC) or outstation site and the applicant has contact with county staff, staff must ask the applicant to complete a SAWS 1 at that time. If the applicant does complete the SAWS 1, it shall be processed per normal procedures. The original copy of the

SAWS 1 is to be filed in the case. The date of application is the date the SAWS 1 was signed.

MEM 50159
MEM 50161

3) If an applicant requests an application over the phone, either at a FRC with a phone-in system or the Public Assistance Information Unit (PAI), county staff are to complete a SAWS 1 using the date of the phone request. The SAWS 1 shall be processed per normal procedures. The original copy of the SAWS 1 is to be filed in the case. The date of the request is the date of application.

4) The date of application will always be the earlier of the two dates if both an MC 210 and SAWS 1 are received separately.

5) If an application is inadvertently sent to another county by a resident of San Diego County and then forwarded by the other county to our county, the date of application is the date stamped by the sending county.

3. PREAPPLICATION PROCEDURES

The procedures described in this section are general preapplication procedures for processing an application for Medi-Cal.

MEM 50142

A. Evaluation of Eligibility for CalWORKs, Food Stamps, SSI/SSP

When reviewing Forms SAWS 1 and 16-2A during the preapplication interview, the preapplication worker will evaluate the applicant's apparent eligibility for CalWORKs, Food Stamps and SSI/SSP.

1) Applicant Appears Eligible for CalWORKs and/or Food Stamps

When the applicant appears eligible for CalWORKs and/or Food Stamps, the worker will:

O.H.
SEC. V

a) Advise the applicant of his/her potential eligibility.

b) Have the applicant modify the SAWS 1 if he/she wishes to apply for any additional aid(s).

c) Document on Form 16-2A that the applicant was advised of potential eligibility for the aid(s) when the applicant does not want to apply for any additional aid(s).

2) Applicant Appears Eligible for SSI/SSP

Applicants who may be eligible for SSI/SSP, and who do not refuse to apply for that program, are referred to the Social Security Administration for a determination of SSI/SSP eligibility.

The worker will:

a) Document the referral in the case file; and

b) Proceed with the eligibility determination of any other program for which the applicant may be eligible, pending the SSI/SSP determination.

B. Evaluation of Eligibility for Medi-Cal

The preapplication worker determines the Medi-Cal program under which the applicant should be processed and explains the eligibility requirements for that program. The worker completes and reviews with the applicant the verification checklist (Form 07-110 DSS) which itemizes the verifications which the applicant must provide in order to determine eligibility as required by MPG Article 4, Section 7. MEM 50167

C. Evaluation of Eligibility for CMS

Adults between the ages of 21 and 64 who have no linkage to any Medi-Cal program will be advised: MEM PROC. 4K

1) That they have no apparent basis of eligibility for Medi-Cal;

2) Of their right to make a formal Medi-Cal application even though they have no apparent Medi-Cal eligibility; and MPG ARTICLE A

3) Of the County's CMS program. If the applicant answered "no" to all of the questions on the Medical Services Screening Sheet (Form 14-4 DSS), give the client a CMS brochure with a list of clinics where the client can apply.

D. Applicant Rights

1) All Medi-Cal Applicants

The worker must inform each applicant of his/her rights under the Medi-Cal Program even if it appears that the applicant is ineligible. The MC 219, “Important Information For Persons Requesting Medi-Cal,” must be given to or sent to the applicant, however, the MC 219 does not have to be returned by the applicant. The worker must document in the case record that the information was provided to the applicant either with a narrative entry or by filing the MC 219 file copy in the case, with the County Use Section completed. MEM 50159, 50161 ACWDL 02-10

2) CalWORKs and Food Stamp Rollovers

a) When an CalWORKs application is denied and a person then wishes to apply for Medi-Cal only, the SAWS 2A that was signed for the CalWORKs application will be acceptable in place of the MC 219. ACWDL 90-72

b) When an applicant requests Medi-Cal after a Food Stamp Only application, he/she must complete the CalWORKs portion of the JA2 and the MC 219.

E. Orientation

The applicant should be encouraged to attend an Orientation. The Orientation is not required for Medi-Cal. The worker explains the Orientation Form 07-33 DSS, has the applicant sign it, and gives both copies of Form 07-33 DSS to the applicant. A copy of the schedule for Orientation presentations is attached to Form 07-33 DSS in the event that the applicant is unable to attend the next available Orientation. MEM 50159 MEM 50161

F. IEVS Informing Notice

The MC 210 (Coversheet) informs Medi-Cal applicants that their Social Security Number (SSN) will be used to access State information on income and resources. The worker will explain that the SSN will be used to match information provided to the State by employers, EDD and financial institutions. The worker will further explain that although applicants who request restricted benefits are not required to provide a SSN, their SSN will be used to access income and resource information if the applicant voluntarily provides a SSN or if the SSN is available through a prior case record. Applicants are to be informed that information received through IEVS is used to ensure that the eligibility and share-of-cost determination is correct and that the information may be verified through collateral contacts when discrepancies are found. ACWDL 91-98

G. Medi-Cal General Property Limitations For All Medi-Cal Applicants

1) "Medi-Cal General Property Limitations for all Medi-Cal Applicants" (MC Information Notice 007) will be given out at application and redetermination. The applicant shall be informed of their right to reduce nonexempt excess property within the month of application, provided the applicant receives adequate consideration. After January 1, 1990, the requirement to receive adequate consideration applies only to an institutionalized individual. ACWDL 89-83

2) "Community Property - Person in Long-Term Care (LTC)" (MC Information Notice 005) shall be given to all applicants with LTC status who have entered an LTC facility prior to September 30, 1989.

3) The worker shall provide options as to how excess property may be reduced and how adequate consideration may be obtained, in order to establish eligibility in the month. This shall be done as soon as there is an indication that the applicant may be ineligible because of excess property. Such options shall include but are not limited to:

   a) Paying of medical or other bills.

   b) Purchasing exempt items.

   c) Paying off mortgages or car loans; making home repairs or improvements to property.

   d) Borrowing against the cash values of nonexempt property and life insurance policies and then reducing the proceeds by receiving adequate consideration.

e) Informing the applicant that the cash surrender value of nonexempt life insurance policies and any other asset will be considered unavailable as long as the applicant continues to make a good faith effort to liquidate the asset. (Refer to Article 9, Section 2).

f) Setting aside up to $1,500 for the individual's burial as a designated Burial Fund. (See Article 9, Section 11.) ACWDL 90-14

4. STATEMENT OF FACTS

A. Effective December 1, 2001, the MC 210 (rev. 8/01) **Medi-Cal Mail-In Application** replaced the previous MC 210 statement of facts. Eligibility staff shall accept either the MC 210 (rev 8/01) or the MC 321 HFP as an application and statement of facts for Medi-Cal. Additionally, a signed MC 210 (rev 08/01), or MC 321 HFP, is an acceptable replacement for the SAWS 1 and now constitutes an official request for Medi-Cal benefits. MEM 50159 MEM 50161

The SAWS 2 may also be used as a Medi-Cal statement of facts when the applicant has previously completed the form as a request for CalWORKs, but was found ineligible. If a SAWS 2 is used as a statement of facts for Medi-Cal, **a signed and dated SAWS 1 is required in the Medi-Cal case.**

The National School Lunch Program (NSLP) revised application may be used as a statement of facts for Medi-Cal for children eligible to free lunch and whose parents have consented to sharing of information according to procedures in 4-2-14.A.6. ACWDLs 03-35, 03-38

The DFA 285-A1 and DFA 285-A2 will be used as a Medi-Cal statement of facts when a Food Stamp recipient requests a Medi-Cal evaluation and the DFA 285-A2 is signed by the Medi-Cal applicant or the applicant's spouse. The DFA 285-A2 must be dated within 12 months of the Medi-Cal evaluation request. Food Stamp recipients may request a Medi-Cal evaluation by submitting a completed Informing Notice 09-83 HHSA. (See 4-2-14.A.5 for application processing instructions.) ACWDL 03-40

Note: The Healthy Families (HF) Program will accept the MC 210 (rev 8/01) or DFA 285-A1/A2 as an application for HF benefits if county eligibility staff determine that a family has a SOC, or is otherwise eligible to HF benefits, and the applicant requested that the MC 210 (rev 8/01)/DFA 285-A1/A2 be forwarded to HF.

B. Persons Who May Complete and Sign the Statement of Facts

As long as the applicant has the capacity to discharge his/her responsibilities, he/she is responsible for participating in the application process. Applicants may designate any person they choose at any time to accompany, assist, and represent them in the eligibility determination process. This means that a person who accompanies the applicant to the face-to-face interview may assist and represent him/her at the interview, help in obtaining required verification, etc. The person may be a family member, friend, representative of an organization, legal aid, or anyone else the applicant chooses. **The person designated may not appear or act in lieu of the applicant, and a competent applicant's participation in the Medi-Cal application process is not excused by designating another person.** MEM PROC. 4I

Certain persons may complete and sign the Statement of Facts when: MEM 50163

1) The applicant has a conservator, guardian or executor. In this case, the conservator, guardian or executor completes the Statement of Facts.

2) The applicant is incompetent, comatose, deceased, or suffering from amnesia and there is no spouse, conservator, guardian or executor. In this case the Statement of Facts may be completed and signed by a relative, a person who has knowledge of the applicant's current circumstances or a representative of a public agency or County department. There is no requirement that the person acting in behalf of the applicant must have prior knowledge of the applicant's circumstances. ACWDL 02-42

   a) If it appears that the relative or other person is not acting in the best interests of the applicant, such as misappropriating income or property of the applicant, or fails without good cause to complete the application process or cooperate with the worker refer the case to Adult Protective Services. Also if the "knowledgeable person" is found to have no real, personal, and specific knowledge of the applicant's affairs, the worker should determine whether another "knowledgeable" person, such as a relative or an LTC representative (if the applicant is in LTC) can complete and sign the MC 210 on behalf of the incompetent applicant. If no such person is available, the worker should complete and sign the MC 210 and perform a diligent search as discussed in Article 4, Section 9.

      When the Statement of Facts is completed and signed by a key person, the worker must give him/her form DHS 7068 to complete (see item 4E).

   b) If the Statement of Facts is completed by a public agency or County representative, follow the diligent search procedures outlined in MPG Article 4, Section 9. MEM PROC 4I

   To be "incompetent" of acting on one's behalf" does not mean that the applicant does not understand English or the application process, or that the applicant just prefers to have someone else act on his/her behalf. The term "incompetence" generally refers to an applicant's mental condition. Regulations do not require that a court or some other entity must first declare that a person is incompetent. When a relative or friend with personal knowledge of the applicant applies indicating that the applicant is comatose, senile, etc. and completes and signs a sworn statement to this effect, then the worker may process the application with that individual acting on behalf of the applicant. (See item 4E) MEM PROC 4I

3) The applicant is incapable of signing because of a physical condition, the applicant should provide the information, and a relative, knowledgeable person, or worker can sign the MC210. If the applicant can make a "mark", a witness should also sign the MC 210.

4) The applicant is a child. The person or agency having legal responsibility for the child completes and signs the Statement of Facts. The child applicant completes and signs the Statement of Facts when any of the following applies:

a) The applicant is 18-21 years of age, not living with a parent or caretaker relative, and the applicant's parents are not claiming him/her for tax purposes;

b) The applicant is 14-18 years of age who is not living with a parent or caretaker relative and who does not have a parent, caretaker relative or legal guardian handling his/her financial affairs; or

c) The applicant is a child applying for Minor Consent Services and meets the requirements specified in MPG Article 4, Section 4.

WHEN THE MC 210 IS COMPLETED AND SIGNED BY SOMEONE OTHER THAN THE APPLICANT OR HIS/HER SPOUSE, THAT PERSON ASSUMES THE RESPONSIBILITIES OF THE APPLICANT AND IS LIABLE FOR DECLARATIONS MADE ON BEHALF OF THE APPLICANT. THUS THE PERSON MUST HAVE REAL, PERSONAL AND SPECIFIC KNOWLEDGE OF THE APPLICANT'S AFFAIRS. THE PERSON MUST BE able TO ANSWER VITAL INCOME AND PROPERTY QUESTIONS WITH A RESPONSE OTHER THAN "UNKNOWN". IF THE PERSON SIGNING THE MC 210 WILLFULLY CONCEALS OR FAILS TO REPORT ESSENTIAL FACTS THAT PERSON, NOT THE APPLICANT/BENEFICIARY, COULD BE REFERRED FOR A FRAUD INVESTIGATION. MEM PROC 4I

C. Authorized Representative (AR)

Some applicants sign an "authorized representative" form, thereby appointing an individual or organization to assist them in establishing Medi-Cal eligibility. Such authorization may also give the assisting person or organization access to confidential information contained in the applicant's case file. For Medi-Cal program purposes, a signed authorization is not necessary in order for the applicant to have someone accompany and assist him/her in the application process. However, a signed authorization is required if the person or organization assisting the applicant wishes to examine the case file in the absence of the applicant or wishes information on case activity. MEM PROC 4I

While the County must allow applicants the right to choose someone to accompany, assist and represent them, applicants continue to have the responsibility to cooperate by completing and signing the MC 210, if there is a face-to-face interview, be present at a the interview, and personally ensure a response to requests for information.

An Appointment of Representative form (MC 306), or any other written authorization signed and dated by the applicant or beneficiary is required for all Medi-Cal cases where an “authorized representative” (including authorized representative with durable powers of attorney) is designated to assist the client in the Medi-Cal application or redetermination process. The AR authorization does not grant the AR the authority to complete the Statement of Facts or attend a face-to-face interview in lieu of the applicant/beneficiary, ongoing case management ability, or access to other programs. The AR is only permitted to assist the client in the interview process, to review the client's case record with or without the client being present, to submit verifications and to represent the client in the hearing process, or to submit verification to and obtain ACWDL 94-99 96-41

information from DED. In addition, the applicant/beneficiary is to understand that if the AR fails to perform as the applicant/beneficiary intends and the application is denied or benefits are discontinued due to that failure, the applicant/beneficiary must accept the consequences of the AR's actions or inactions.

A written AR authorization is to be recognized for one year from the date signed. If a DED packet is sent for the client, a copy of the AR authorization must be enclosed. If a written AR authorization is received after the DED packet was sent, a copy of the authorization needs to be sent to SP-DED along with a MC 222. ACWDLs 96-41 97-01

Questions and Answers

Q. 1: Is the MC306 or other AR authorization used for authorization of “key person”?

A. 1: No. The term “key person” is not a Medi-Cal term. Some counties refer to “key person” as someone who assumes case management responsibility for incompetent individuals. Form DHS 7068 (7/94) is to be used when an incompetent Medi-Cal applicant/beneficiary has a public guardian/conservator or representative acting on his/her behalf. Refer to Article 4, Section 2, item 4E for detailed regulatory requirements regarding public guardian/conservator or representative acting on behalf of an incompetent Medi-Cal applicant/beneficiary.

Q. 2: What do we do if the applicant/beneficiary or the AR refuses to sign the authorization?

A. 2: If the AR or the applicant/beneficiary refuses to sign, then the individual will not be recognized as the AR.

Q. 3: Does the authorization take the place of the MC 219 in regard to reporting responsibilities, penalty for fraud, etc.?

A. 3: No, it does not take the place of the MC 219. The applicant/beneficiary is still the responsible person and the responsibility to provide truthful and accurate information rests with the applicant/beneficiary.

Q. 4: Current regulations allow the applicant to appoint legal aid or an organization to be his/her AR. Does this regulation change?

A. 4: No. The regulations referred to are in the Department of Social Services Manual of Policies and Procedures and are concerned with the applicant's right to representation in the hearing process. However, CDHS has reexamined these regulations and it is thought that presently an organization, law firm or group MAY be the selected AR. However, an individual from that organization, law firm, or group will still have to be designated on the authorization so that the client and the county will know which person from the organization, law firm or group is the person empowered to be the contact person. If the designated individual no longer works in that capacity then a new authorization will have to be completed to designate another individual.

Q. 5: Can a client have more than one AR?

A. 5: Yes, a client may have any number of persons acting as his/her AR. However, each individual must be designated on a separate Appointment of Representative form and the client and the AR must sign each form.

Q. 6: After the AR and the client complete the authorization, can the AR obtain information directly from other sources, such as bank balances, income, etc., with this form?

A. 6: No. The AR authorization is not an all-inclusive release of information authorization. It is meant only to allow the AR to work with the client and the CWD, to assist the client in obtaining benefits, in completing the yearly redetermination or appeal process and to provide verifications to, or obtain information from DED. No other powers or authorities are given.

Q. 7: Is the AR entitled to receive the client's Benefits Identification Card (BIC)?

A. 7: Many forms used by organizations acting as ARs state that the AR has the right to obtain the Medi-Cal card, medical records, etc., from the CWD and other agencies. This is not correct. The Medi-Cal card, or the plastic BIC, can only be issued to the applicant/recipient and the other individuals in the case.

Q. 8: What powers does the AR have?

A. 8: The AR may:

1. Submit/provide requested verifications, medical records and other information to the CWD and/or DED;

2. Accompany and assist the applicant/beneficiary during any face-to-face interview and in the hearing process;

3. Obtain information from the CWD and DED regarding the status of the application;

4. Receive a copy of a specific notice of action from the CWD at the request of the applicant/beneficiary; and ACWDL 96-41

5. Review the case record with or without the client's presence.

Q. 9: What if the client wants the AR to provide additional legal services or gather additional information from third parties on his/her behalf?

A. 9: The AR authorization is only an authorization for the AR to perform those functions as stated in Answer 8, it has no other authority or purpose. Any other services that the client wants the AR to perform, such as obtaining

information from third parties, must be arranged separately among the client, AR and the third party.

Q. 10: Does the case number or Social Security number (SSN) have to be completed on the MC306, and what if the applicant is an undocumented alien?

A. 10: The case number or SSN line on the form is to allow easier case identification for the county. Both the case number and SSN are optional. If the applicant/ beneficiary is undocumented and applying for restricted benefits, then they do not enter a SSN.

Q. 11: How does the client revoke the AR designation?

A. 11: The client may revoke the AR designation at any time, either orally or in writing. If the revocation is verbal, the county should obtain a written confirmation within a reasonable period of time. If the county has not yet received a written confirmation on the verbal revocation, the worker should notate on the authorization that it has been revoked, the date of the revocation along with the name, address, and phone number of the person requesting the revocation. The worker should also write his/her name and phone number after the above notations have been made. The worker must also make a narrative comment in the case when changes in the AR occur. Should an AR designation be revoked the worker must not permit an exchange of information to continue with the former AR.

Q. 12: How is the AR authorization to be completed and where to file it?

A. 12: While the authorization does not have to be completed in the presence of the worker, it is important that the worker review it with the client. If the AR is an organization, law firm, or group, the individual chosen to receive/submit information on behalf of the client and the AR organization, is entered with the organization named.

Three copies of the form will be needed. The client and the AR must each receive a copy of the completed form and one must be kept in the case record.

The AR authorization should be placed on top of the Statement of Facts so that the worker will know at a glance who the current AR is and how to get in touch with him/her. AR forms that have been revoked should be kept in the case file.

Q. 13: Should the County Welfare Department (CWD) accept an AR authorization if the applicant/beneficiary signed and dated the form several days before the AR signed and dated the form? ACWDL 95-60

A. 13: It is conceivable that an applicant/beneficiary may have decided to appoint someone to act as his/her AR, signed, dated, and mail the form to the individual designated as the AR to sign and date. This is acceptable. However, if the signatures/dates are more than a few days apart, there is a possibility that the applicant/beneficiary was coerced into signing the authorization form or did not know the identity of the designated AR. The worker must establish, to his/her satisfaction, that the applicant/beneficiary freely chooses the AR, understand his/her own rights and responsibilities, and understand what the authorization enables the AR to do on his/her behalf.

If the AR authorization has been signed and dated by the applicant/beneficiary more than two weeks before the AR, the worker should do the following:

- If the applicant/beneficiary has a phone, the worker should call the applicant/beneficiary to determine if he/she has knowledge of the individual or organization designated and has consented to that person or organization acting as the AR. The applicant/beneficiary's response should be noted in the case narrative.

- If the applicant/beneficiary does not have a phone or phone contact cannot be made, the worker should send a letter to the applicant/beneficiary to confirm the designated AR.

In either case, if the applicant/beneficiary responds that he/she has not designated the individual or organization to act on his/her behalf, or responds that he/she was not given a choice in the designation, the worker should inform the applicant/beneficiary that the AR form is revoked. If he/she still wishes to designate someone to assist him/her, another authorization will have to be submitted.

If no phone contact is made with the applicant/beneficiary and no response is received by the date stated in the letter, the worker should deny or discontinue Medi-Cal based on the loss of contact and an appropriate Notice of Action (NOA) should be issued. If the worker has sufficient information to grant the Medi-Cal application, it will be approved with a discontinued NOA sent effective as of the end of the current month based on loss of contact.

Q. 14: If the applicant/beneficiary and the AR do not sign the authorization on the same day, what is the effective date of the AR authorization?

A. 14: The effective date is the later date when all signatures and dates have been completed.

Q. 15: May a health provider or an AR use the AR authorization to determine if someone has applied for Medi-Cal?

A. 15: No. If the worker receives a properly signed and dated authorization with a request to determine if the individual has applied for Medi-Cal, the request should be denied. If the AR does not know if an application has been made, it would appear that the applicant was given the form as part of an admission/treatment packet which is not allowed under federal policy. While the MC 306 states the AR may "obtain information from the CWD and from the California Department of Health Services (CDHS), Disability Evaluation Division (DED), regarding the status of the application," it is understood an application should have already been made. The authorization should not be completed until such application has been filed. The AR authorization is not to be used to confirm an applicant/beneficiary's eligibility to the provider.

Q. 16: May the AR be allowed access to the case record if the applicant/beneficiary is not in attendance?

A. 16: Yes. ACWDL #96-41

Q. 17: Can the CWD refuse to accept a SAWS1 from anyone other than the applicant?

A. 17: No. Regulations permit the applicant to file the SAWS1, or, if the applicant is unable to apply on his/her own behalf, for any reason, the applicant's guardian/conservator, a public agency representative or a person who knows of the applicant's need to apply may complete and file the SAWS1 on behalf of the applicant.

The CWD may <u>not</u> refuse to accept the initial application (SAWS1) from anyone. However, the applicant, if competent, must complete the MC 210, AR authorization, and provide any other document or verification needed to establish eligibility.

Q. 18: Has CDHS formulated any type of sanction to be applied to ARs found to be negligent or in willful violation of state/federal law?

A. 18: Yes. When CDHS becomes aware of ARs, either individuals or groups, who are being negligent in their duties as AR, or found to be coercive or violating CDHS's policy on an on-going basis, CDHS will write a letter informing the AR of SDHS's policy and advising them of the correct way to perform the AR function. Should complaints be received after that time, CDHS will advise the CWD to refer the AR to the State Department of Justice for investigation. SDHS will handle each instance on a case-by-case basis, SDHS is continuing to explore a formal sanction process.

Q. 19: Is an AR entitled to receive a Letter of Authorization (LOA) for billing purposes?

A. 19: No. The LOA is only to be issued to the beneficiary or beneficiary's family. The beneficiary is responsible for providing the LOA to the appropriate provider of service. However, a provider may request a replacement LOA if, for some reason, they have not been able to submit the LOA to EDS within 60 days of the date of the LOA.

Q. 20: If a beneficiary wants a neighbor to deliver information to the county or to see the worker to discuss how share-of-cost was determined, does the beneficiary need to complete a written AR authorization? ACWDL 96-20

A. 20: The beneficiary should call and inform the worker that he/she would like the neighbor to see the worker. In addition, the beneficiary should write and sign a short note authorizing the individual to act on his/her behalf for that specific function and on that specific date.

Q. 21: Is it the county's responsibility to prepare and provide a "conflict of interest" waiver when an AR represents both the applicant/beneficiary and the medical provider?

A. 21: No. Any "conflict of interest waiver" is the responsibility of the AR and is not required by CDHS. The county should not indicate that one is necessary to an AR who is representing both parties, if the AR thinks that it is in his/her best interest in those cases of double representation.

Q. 22: An 18-year old male was in a car accident and hospitalized in County A. An AR firm, which provides AR services for the hospital, had the 18-year old sign the AR authorization designating this firm as his AR. The AR forward the AR authorization, SAWS1 and MC 210, etc. to County A.

It is determined later that the 18-year old was visiting friends in County A, where he was injured, but he actually lives with his parents in County B and is a dependent of his parents. The AR firm knew of this fact but refused to have the parents apply for Medi-Cal in County B. In fact, the parents refused to apply.

Should County A accept the AR authorization and other forms and determine Medi-Cal eligibility?

A. 22: No. The parents are responsible for their child and, if the parents wish to, must apply for him. Also, they may designate an AR. The youth is not able to do so in this case because he is not the person responsible to apply for Medi-Cal. It also appears that the AR firm is attempting to act in lieu of the youth's parents which is not permitted. County A should deny the application and refer the parents to the appropriate CWD if they would like to apply for benefits. The AR's intervention is denying the parents the right to choose whether or not to apply for Medi-Cal.

If the parents apply in County A where their child is hospitalized, County A should accept the application, determine eligibility, and transfer the case to County B where the family lives.

Q. 23: Are there any circumstances in which the worker should send a copy of a notice of action (NOA) automatically to the AR?

A. 23: Yes. Copies of all NOAs in conjunction with a hearing must be sent to the AR. MPP Section 22-0104 states:

"After a person or organization has been authorized to represent the claimant, the county, after notification of the authorization, shall send copies of any subsequent correspondence that it has with the claimant regarding the state hearing, to the claimant and the authorized representative simultaneously."

In other situations, the worker must use good judgment to decide if a NOA should be sent to the AR at the same time it is sent to the applicant/beneficiary. For example, if an applicant/beneficiary does not speak or read English and the county does not have the NOA in the individual's primary language, the worker will send a copy of the NOA to the AR so the applicant/beneficiary is not adversely affected due to circumstances beyond his/her control.

D. Authorized Representative (AR) with Durable Powers of Attorney (DPA)

1) Definition

ACWDL 94-70

A **power of attorney** is a "written instrument, however denominated, that is executed by a natural person having the capacity to contract and that grants authority to an attorney-in-fact. A power of attorney may be durable or nondurable." A DPA contains a clause which states that it will not be affected by the incapacity of the principal (person who appoints the attorney-in-fact who is the individual acting on the principal's, or applicant's behalf), or it may state that the DPA will become effective at the time the principal becomes incapacitated.

There are two forms of DPA:

a) Durable Power of Attorney for Property Management (DPAP) which authorizes an attorney-in-fact to handle an individual's financial affairs; and

b) Durable Power of Attorney for Health Care (DPAHC) which empowers an attorney-in-fact to make health care decision for the principal.

For purposes of obtaining Medi-Cal benefits, the DPAP would be used. The DPAP may become effective immediately upon its execution or it may be a "springing" DPAP which does not become effective until the principal becomes incompetent. If it does become effective immediately, the principal **does not relinquish his or her**

own authority. In this case, either the principal or the attorney-in-fact may act on the principal's behalf. However, Civil Code Section 2304 states:

> "An agent may be authorized to do any acts which his principal might do, except those to which the latter is bound to give his personal attention."

For a DPAP to be valid, it must have been executed by a competent adult. Civil Code Section 1556 prohibits a DPA from being executed by minors, persons of unsound mind, or persons deprived of civil rights (incarcerated or institutionalized).

2) Powers of an Authorized Representative with a DPAP

While any competent adult may designate an AR, with or without a DPAP document, to assist him or her in the Medi-Cal process, that assistance is limited in scope. This AR may complete the initial application for benefits, SAWS1, and may assist the applicant in the interview and in obtaining verifications. However, neither federal nor state law allows for the AR to act in lieu of the applicant. The applicant, referred to as the principal in a DPAP document, must still act on his own behalf in those instances whereby he "is bound to give his personal attention," such as:

a) Completion and signing the Statement of Facts; and

b) Participation in the face-to-face interview.

In addition, the applicant maintains the ongoing responsibility for reporting any changes to his/her circumstances that may affect Medi-Cal eligibility.

The possession of a DPA does not confer any additional authority to act on an individual's behalf for the purpose of obtaining Medi-Cal benefits. Additionally, the AR's authority to act on behalf of the applicant/recipient expires either:

- At the granting of benefits;
- At the conclusion of the redetermination process;
- After the time limit expires for the requesting of a fair hearing; or
- At the conclusion of the fair hearing process.

Applicants should be made aware that the DPA is a very powerful document and may be used inappropriately by unscrupulous persons, especially since the DPA eliminates the need for court-supervised conservatorship. The DPA should be reserved for situations where it is determined that the principal can safely and properly grant the desired authority to a trusted agent. MEM PROC. 133

E. Public Guardians, Conservators or Representatives (key person) Acting on Behalf of Incompetent Individuals

1) Definition

Authorized Representative:

A person specifically designated in writing by the applicant/beneficiary to accompany, assist and represent the applicant/beneficiary in the Medi-Cal application/redetermination or fair hearing process. An authorized Representative cannot act on behalf of a Medi-Cal applicant/beneficiary.

Conservator:

A person appointed by the court to act as the guardian, custodian or protector of another.

Public Guardian:

A county agency acting as a public entity appointed to act on behalf of persons who have lost their ability, either mentally or physically, to handle their own affairs. The **Public Guardian** acts as the individual's advocate. No private person is allowed to be a "public guardian."

Representative (aka Key Person):

A person acting on the behalf of another who is incapable of handling his/her own personal or business affairs. The representative must have specific and personal knowledge of the incompetent individual's current circumstances. The **Representative** may be a friend, relative or someone else who has known the applicant/beneficiary and will act responsibly on his/her behalf. ACWDL 02-42

2) Who May Apply

Whether or not the applicant is incompetent, anyone who knows of an individual's need may apply for Medi-Cal on that individual's behalf by completing and filing the SAWS 1 initial application form, and if: ACWDL 94-62

a) The individual is competent, he/she is responsible for providing all necessary information and verifications and for completing all documents.

b) The individual is incompetent, the Statement of Facts must be completed, in rank order, by the applicant's spouse, or, if the applicant has a conservator, guardian or executor, then the conservator, guardian or executor.

If there is no spouse, conservator, guardian or executor, then the worker shall evaluate the applicant's circumstances and determine whether or not there is a need for protective services.

If a need for protective services is not found, then the Statement of Facts may be completed and signed on the applicant's behalf by a relative, a person who has knowledge of the applicant's circumstances, or a representative of a public agency or the County department.

The phrase, "a person who has knowledge of the applicant's circumstances", may be interpreted in a broad sense. The office manager, administrator or social worker of a nursing facility MAY have sufficient information and knowledge of the applicant's circumstances if the applicant's income/property are known to them. Many nursing facilities maintain a trust account for their patients in which a patient's income is automatically deposited and funds are dispersed by the facility. In these instances, if no other family member is involved and protective services are not warranted, the facility staff person may file the SAWS 1 and complete the eligibility process in lieu of the patient.

3) Roles And Responsibilities Of Public/Private Conservators

Probation Code 2401 & SDHS Letter Dated 10/19/95.

a) A conservator has the management and control of the conservatee's estate, and is required to perform all the tasks that a Medi-Cal applicant/beneficiary would be required to perform.

b) If the conservator is a government agency, its designees will be permitted to take on the functions of the conservator. No face-to-face interview is required for a public agency conservator.

c) An individual who has obtained a court ordered conservatorship has the ability and responsibility to act fully for the conservatee but may not delegate another party to assume those duties (such as the Intake face-to-face interview, etc.). The private conservator may, however, designate an Authorized Representative (AR) to assist him/her as any other competent applicant/beneficiary may do, and these ARs are only permitted to perform those functions stipulated on the MC 306, Appointment of Representative form.

d) The private conservator is required to assume all activities necessary to determine eligibility whether he/she has an AR or not. If the worker believes that the AR is not acting in the best interest of the conservator or the conservatee, the worker will so advise the conservator and suggest that he/she revoke the MC 306 and appoint another AR if he/she so desires. The conservator is, however, ultimately responsible for the applicant/beneficiary and is subject to being removed as the conservator if he/she does not act responsibly. The worker should refer these situations to the Public Guardian's Office or the State Medi-Cal Fraud Bureau.

4) Reporting Responsibilities Of Public Guardian/Conservators Or Applicant/ Beneficiary Representatives

It is very important that the public guardian/conservator or applicant/beneficiary representative be aware of his/her ongoing responsibilities of timely reporting changes to income, property, health coverage or any other changes that may affect eligibility of the applicant/beneficiary whom he/she represents. The following forms are required to be used to inform the public guardian/conservator or representative of these responsibilities:

DHS 7068 (Responsibilities of Public Guardians/Conservators or Applicant/ Beneficiary Representatives):

This form sets for the responsibilities of those individuals to the incompetent applicant/beneficiary as court appointed or volunteer representatives, and is to be given or mailed to the public guardian, conservator or representative at the time of the initial application and at each redetermination, and is signed under penalty of perjury. This form is printed on NCR paper. The white copy (top sheet) is to be kept in the case file, the yellow copy is to be kept by the public guardian, conservator or representative. The signature, address and telephone number of the public guardian, conservator or representative is required on the form.

MC 219 (Important Information for Persons Requesting Medi-Cal):

This form must accompany the DHS 7068. The MC 219 must be signed and dated by the public guardian, conservator or representative and kept in the case file.

5) Methods To Determine an LTC Patient's Incompetency

The worker may reach an incompetency decision by one of the following methods:

a) Calling the LTC facility and inquiring as to the patient's ability to handle his/her own affairs;

b) Obtaining a statement from the patient's physician;

c) Making a "home visit" to the facility to communicate with the individual; or

d) Obtaining satisfactory evidence from family members which would provide the worker with sufficient reason to believe that the LTC individual is incapable of handling his/her own affairs. Such evidence may include conservatorship documents or a written statement from a family member stating that the individual is unable to complete the application process.

6) Referral to Public Guardian

Ultimately, the worker may assume total control of a Medi-Cal case if:

a) The applicant is unable to apply for or complete a Medi-Cal eligibility determination process due to incompetency, or being in a comatose condition or suffering from amnesia; and

b) The applicant does not have a spouse, conservator, guardian or executor; or

c) An applicant has a representative assuming case management responsibilities due to the applicant's mental condition, but the representative becomes non-cooperative or if contact is lost.

In these situations, the worker must refer the case to protective services to determine if the public guardian or adult protective services staff should become the responsible agent.

Note: For incompetent Craig v Bonta beneficiaries only, if the beneficiary does not have a representative, the worker must complete form 14-78, PUBLIC ADMINISTRATOR/CRAIG V BONTA REFERRAL. When completing the section where the form asks "State examples of probable cause…" the worker is to write the reason why the beneficiary is unable to handle his/her own affairs. The original of the 14-78 is to be forwarded to Mail Stop O-95, attention: Craig Liaison. A copy of the form is to be filed in the case. ACWDL 03-25

7) Diligent Search

If the worker does not refer an incompetent beneficiary to protective services/Public Guardian, he/she must undertake a diligent search of known information to determine eligibility (refer to MPG Article 4, Section 9 for diligent search procedures). If the applicant is eligible, the worker will complete and sign the MC 210 Statement of Facts. Additionally, the MC 210 must be countersigned by another representative of the County Welfare Department (CWD) who shall also confirm, by personal contact, the inability of the applicant to act on his/her own behalf. (The case worker's supervisor may make a phone call to the facility to confirm the client's incompetency and countersign the MC 210.)

8) Non-Cooperation Of The Acting Individual

LTC applicants should not be denied Medi-Cal due to the non-cooperation of the individual acting on their behalf. In these cases, unless a suitable individual is located, the non-cooperative individual should be notified that the application is denied. The worker shall then proceed by filing a second SAWS 1 as well as an application for retroactive coverage if the second SAWS 1 is filed after the month in which the initial SAWS 1 was submitted. The worker should proceed with the diligent search procedures in order to make the appropriate eligibility determination.

9) LTC Patient's Income And/Or Property Are Exploited By Another Person

In situations where it appears that the LTC patient's income and/or property may be or is being exploited by another person, the worker must:

a) Notify the source agency where the income originates (Social Security Administration, Veterans' Administration, etc.). If the worker receives information that the income will temporarily cease until a representative payee is found, the worker should regard the income as unavailable and not count it toward a share of cost; or

b) Refer the case to the public guardian, adult protective services (APS) or the LTC ombudsman if it appears that a bank account or other property may have been exploited. Once the referral has been made to the public guardian, APS or the LTC ombudsman and they have responded indicating that they are taking steps to recover the property, the worker should treat that property as unavailable until the property has been seized.

10) Address on Case Record and Mailing of NOA/Correspondence

In cases where the applicant/beneficiary has been determined incompetent to handle his/her own affairs, and there is a public guardian, conservator or representative (key person) acting on his/her behalf, all NOAs and correspondence must be mailed to the public guardian, conservator, or representative (key person). To ensure that this requirement is met, the worker will:

a) If the public guardian, conservator or representative (key person)'s address is in California — County Policy

On BDLM, the "Application" screen:

- Enter the **public guardian, conservator or representative (key person)'s name** in the "**payee**" **field.**
- Enter the word **For** in the "**PM**" **field**.
- Enter the **beneficiary's name** in the **first "address" field.**
- Enter the **public guardian, conservator or representative (key person)'s address** in the **following "address" fields.**

Example: Charles Smith is acting as a representative (key person) for his cousin Bill Johnson (beneficiary) who is mentally incompetent. In this case, enter **Charles Smith** in the "**payee**" **field; For** in the "**PM**" **field; Bill Johnson** in the **first "address" field** and **Charles Smith's address in the following "address" fields.**

Note: When the representative's address is used, the BIC will be sent to the representative also. This is allowable. — CDHS Clarif 10/3/97

b) If the public guardian, conservator or representative (key person)'s address is outside California

The requirement to use the representative's address in the case record as indicated above does **not** apply to cases which have a conservator or representative (key person) who is residing outside California. The Medi-Cal applicant/beneficiary's name and address will continue to be entered for those cases. The reason is to avoid Medi-Cal eligibility not being established in MEDS and BIC not being issued due to an out of State address being used for the case record.

However, in order to ensure that NOAs and all correspondence are mailed to the conservator or representative who resides outside California, the worker will place the form **DHS 7068 — Responsibilities of Public Guardians/ Conservators or Applicant/Beneficiary Representatives**, on top of the most recent 278F to serve as a reminder to this requirement. The address of the public guardian, conservator or representative is included in this form.

It is not necessary to send a copy of a NOA or correspondence to the incompetent Medi-Cal applicant/beneficiary. CDHS Clarif 9/12/97

In cases where the public guardian, conservator or representative (key person) has requested that a copy of the NOA be sent to the administrator of the LTC facility where the Medi-Cal applicant/beneficiary resides, the worker may copy the original NOA and mail it to the LTC administrator. The NOA back which provides Appeal information is not required. CDHS Clarif 10/3/97

GENERAL QUESTIONS AND ANSWERS

Q. 1: When a nursing facility or other medical provider provides the CWD with a MC 1708 (Medical Report - Medical Assistance Only) to substantiate mental incompetency, may the CWD regard all resources such as bank accounts, etc. as unavailable?

A. 1: No. The availability of property must be determined separately from the incompetency issue. Even if the applicant is regarded as incompetent (this includes individuals in a comatose or unconscious state) and unable to handle his/her own affairs, if another individual (family member, friend, etc.) can get access to the property then it must be regarded as available. Many elderly persons have friends or relatives listed on bank accounts and this joint access situation should be determined. If the incompetent individual is the only person who has access, the account will be regarded as unavailable. Form MC 1708 will no longer be used by SDHS. There are other acceptable ways to verify incapacity and disability.

Q. 2: After a LTC applicant has been determined to be incompetent, does he/she have to complete and sign an Appointment of Representative (AR) form?

A. 2: No. A Medi-Cal applicant who is incompetent is presumably incapable of demonstrating the required knowledge and ability necessary to designate an

authorized representative. An AR form would not be appropriate in these instances. No written authorization is required for an individual to assist an incompetent person to apply for benefits.

Q. 3: If an LTC patient is competent, does he/she have to complete and sign the AR form?

A. 3: Yes, if the applicant designates someone, other than a family member, to act on his/her behalf, the applicant must complete and sign an AR form. In this situation, the applicant must be given the same rights and responsibilities under the law and Medi-Cal regulations to participate in the application process.

Q. 4: What would be the best course for the worker when it is found out that the representative (key person) has failed to report changes to the department?

A. 4: The worker shall request all information necessary to determine the applicant/beneficiary's eligibility/continuing eligibility and/or share of cost from the representative as the worker otherwise would do with any other clients. If the representative refuses or fails to provide the requested information by the due date, he/she shall be considered non-cooperative.

5. STATEMENT OF CITIZENSHIP/ALIEN STATUS

All Medi-Cal applicants are required to provide a statement of citizenship/alien status which is used to determine what level of benefits they are potentially eligible for.

A. Completion Requirements

ACWDL 03-14

1) Forms Which Satisfy This Requirement

ACWDL 91-10

ACWDL 92-48

a) MC 210 (8/01), MC 321 HFP, or MC 368 (covers adults who sign and their children listed on the application),

b) SAWS 2,

c) Sworn statement (containing declaration of citizenship/national status and place of birth),

d) MC 13.

2) Who Completes

A statement of citizenship/alien status must be completed for all Medi-Cal applicants and beneficiaries. Each adult applicant for Medi-Cal must complete and sign a statement of citizenship/alien status. An adult may make this statement for children under age 21. In cases where the applicant is incapable, incompetent, or deceased, the same person who signs the MC 210 must make the statement.

a) For U.S. citizens/nationals,

(1) If the statement of facts is the MC 210 (8/01), SAWS 2, or MC 321 HFP, then the declaration on that form regarding citizenship/national status is an acceptable statement of citizenship/alien status for the adult who signed to form. For two adult households, the worker may either request both adults to sign the form, or accept one signature and obtain an MC 13 or sworn statement for the other adult.

(2) If the statement of facts is the DFA 285A2 or the AIM application, an MC 13 or sworn statement must be completed.

b) For non-citizens, an MC 13 must be completed. EXCEPTION: MC 321 HFP's which are received through the Single Point of Entry (SPE) do not require an MC 13 (see MPG Article 4, Section 20, Part 5).

B. Form MC 13

MEM PROC. 7G

1) How to Complete

SECTION A. MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

This section includes a variety of important information to help applicants understand the citizenship/alienage requirements of the Medi-Cal program including the definition of Satisfactory Immigration Status (SIS). This section also includes information about alien documentation and verification requirements and SSN requirements.

SECTION B. CITIZENSHIP/IMMIGRATION STATUS DECLARATION

This section is designed for the applicant to indicate whether he/she is a U.S. citizen, national or an alien, without reference to the level of benefits requested. Every applicant is required to answer question 1 indicating whether he/she is or is not a citizen or national of the United States. Every applicant who indicates that he/she is a U.S. citizen or national must provide information about his/her place of birth and then skip to Section D. Anyone who indicates that he/she is not a citizen or national of the United States MUST provide information about his/her specific alien status in questions 2 through 4. If none of the alien statuses in questions 2 through 4 is applicable, the applicant shall answer "NO" to EACH of those questions. Aliens who claim to be PRUCOL must indicate which PRUCOL category applies to them in question 5. **AN MC 13 INDICATING THAT THE APPLICANT IS NOT A CITIZEN OR NATIONAL OF THE UNITED STATES IS INCOMPLETE UNLESS THE APPLICANT INDICATES A SPECIFIC ALIEN STATUS (INCLUDING A SPECIFIC PRUCOL STATUS AS APPLICABLE) OR ANSWER "NO" TO QUESTIONS 2 THROUGH 4**.

SECTION C. VERIFICATION OF IMMIGRATION STATUS

Only aliens who answer "yes" to question 2, 3 or 4 in Section B are required to complete Section C. This is because verification of an applicant's alien status is only required if he or she claims to have "SIS". Aliens who claim to have SIS are required to provide documentation of their immigration status. These aliens have 30 days (or the time it takes to determine whether they are otherwise eligible, whichever is longer) to present evidence of SIS.

If they are otherwise eligible, grant them full Medi-Cal benefits without further delay (even without evidence of SIS) if the 30 days to present evidence of SIS have not elapsed. In addition, such applicants, if they present evidence of SIS and if they are otherwise eligible, receive full benefits while their evidence is being verified with the INS through the Save system.

If an applicant claims SIS but needs to obtain replacement immigration documents, the requirement to provide evidence of SIS shall be considered met if the alien presents an individual Fee Register Receipt (INS Form G-711) requesting replacement of lost, stolen or unreadable INS document.

SECTION D. SOCIAL SECURITY NUMBER (SSN)

Every applicant who has a SSN is asked to provide it regardless of his/her citizenship or immigration status. Therefore, every applicant must indicate whether or not he/she has a SSN in this section. **However, only applicants who claim to be U.S. citizens or nationals, or aliens with SIS, are required to provide (or apply for) a SSN as a condition of eligibility.** Refer to Article 4, Section 11 for acceptable SSN verification and procedures to be followed when an applicant who is required to provide a SSN but does not have one at the time of application.

It is appropriate to ask an applicant who is otherwise eligible for restricted benefits to provide the SSN, if he/she claims to have one. However, if such an applicant refuses to provide the SSN, restricted benefits must be granted if the applicant is otherwise eligible. The worker should request an investigation if there is reason to believe that the applicant is withholding any information relevant to his/her Medi-Cal eligibility or SOC.

UNDER NO CIRCUMSTANCES SHOULD A WORKER KNOWINGLY SUBMIT AN INCORRECT OR FRAUDULENT SSN TO MEDS.

COUNTY USE SECTION

This section provides space for important information about the citizenship/alien status determination. The worker should provide all of the applicable information requested in this section. The "Action Taken" categories have been expanded to indicate when full benefits are granted pending verification of immigration status. The worker should mark this response when full benefits are granted to an otherwise eligible alien during the reasonable opportunity period to provide evidence of SIS and/or while waiting for the INS to verify SIS through SAVE. The revised MC

13 (7/96) also adds a section for the worker to indicate which level of benefits the applicant is potentially eligible to receive, based on the citizenship/immigration status information provided on this form.

2) When to Complete

A statement of citizenship/alien status must be completed:

a) At application and reapplication;

b) An MC 13 must be completed when an alien reports a change in immigration status;

c) When a beneficiary requests a new level of benefits;

d) When adding a person to the MFBU; and

EXCEPTION: A statement of citizenship/alien status is not required for one year when adding a newborn under Deemed Eligibility. ACWDL 03-49

e) At redetermination for current beneficiaries who did not previously complete a statement of citizenship/alien status. Once the beneficiary has a statement in file, there is no need to complete an additional statement unless there has been a change in the beneficiary's immigration status.

3) Failure to Complete Form MC 13

Completion of Form MC 13 is required for all non-citizens who request Medi-Cal benefits. Citizens may complete this requirement on the statement of facts, or with a sworn statement. Applicants who fail or refuse to complete the required sections of Form MC 13 are to have their request for Medi-Cal benefits denied. Only those persons for whom Form MC 13 completion requirements are not met are to be denied benefits. These persons are to be considered ineligible members of the MFBU. ACWDL 03-14

6. MEDICAL SUPPORT REFERRAL MEM 50185

Medically Needy Only (MNO) applicants must cooperate with the Medical Support Enforcement Program when requesting Medi-Cal for a child born out of wedlock or with an absent parent. An applicant must complete all the forms necessary to process a medical support referral to the Family Support Division of the District Attorney's Office. See Article 4, Section 18 for forms and referral procedures.

An applicant who refuses to cooperate without good cause with the Medical Support Enforcement Program will be determined to be an ineligible member of the MFBU.

7. APPLICATION FOR RETROACTIVE MEDI-CAL

A. Retroactive and Ongoing Medi-Cal Requested

An applicant/beneficiary (including a minor consent applicant) may request retroactive Medi-Cal for any of the three months preceding the month of application. If not requested at application, the request for retroactive Medi-Cal coverage must be made within one year of the month for which retroactive coverage is requested. A request for retroactive Medi-Cal may be made:

1) On the application form;

2) On the Statement of Facts; or

3) By submitting a written request.

The applicant will complete Form MC 210A, Supplement to Statement of Facts, for the retroactive months.

QMB only clients are not eligible to retroactive Medi-Cal.

B. Application for Retroactive Medi-Cal Only

When the applicant requests retroactive Medi-Cal only, the applicant completes Form MC 210 for the earliest retroactive month. Form MC 210A is completed for each additional retroactive month. The worker will open pend the case for the earliest retroactive month requested.

C. Retroactive Medi-Cal for CMS Beneficiaries

County Policy

If an applicant is identified as having CMS coverage during any month in the retroactive period, an application for retroactive Medi-Cal must be completed. Workers must check the applicant's statements on the 16-2A HHSA and MC 210 to see if they declare CMS coverage. Workers will also be able to check for CMS eligibility on an IDX screen print (see Appendix 4-2-A) which will be required in cases coming from HOS staff. HOS staff are required to attach the IDX screen print in each case file to show whether or not an applicant was in receipt of CMS in the retroactive period. Since the county can be reimbursed for medical expenses covered by CMS, a CMS beneficiary who may possibly have a disability that potentially links him/her to Medi-Cal must apply for and cooperate in completing an application for Medi-Cal. The CMS beneficiary should be encouraged and assisted as needed to complete the application. If the CMS beneficiary fails to cooperate, the worker must narrate the reason why the retroactive application was not completed. If a CMS Medi-Cal referral form, HHSA:CMS-5, was provided by the applicant, the worker is to complete the form and forward to CMS as indicated on the form distribution. These applications must be referred to SP-DAPD (see Article 5-4-3.C). HOS staff must attach a copy of the IDX screen print when banking the case.

D. Retroactive Medi-Cal Application Process

All requests for retroactive Medi-Cal are processed manually by intake workers. Assignments are made according to district policy.

1) Intake Procedures

The intake worker will:

a) Have the applicant complete Form MC 210A for the retroactive months. If only retroactive Medi-Cal is requested, Form MC 210 is completed for the earliest retroactive month; and

b) Income verification used to determine current month eligibility on the signed and dated MC 210 can be used to determine income eligibility for each retroactive month provided "no change" is indicated on the MC 210 A. Applicants or beneficiaries are required to provide income verification for each retroactive month where a change of income is reported on the MC 210 A. ACWDL 02-43

Only one pay stub is required to verify income, as long as it adequately reflects the actual retroactive month(s) income. Self-employment income verified and calculated at initial application can also be used for each retroactive month requested provided it adequately reflects actual monthly income. Workers may request further income verification if income reported is inconsistent with the income verification provided.

Examples ACWDL 02-43

Ex. 1: Applicant applies for Medi-Cal on May 6, 2002. Applicant states on the MC 210 they are paid $200 weekly (every Friday) and provides one pay stub dated May 3, 2002 as income verification. Worker determines current month income and projects future month income from the pay stub provided.

Applicant applies for retroactive Medi-Cal for the months of April and March 2002, completes the MC 210 A, and indicates "no change" to income for retroactive months. Based on the single pay stub provided and "no change" indicated on the MC 210 A, the worker determines:

- $800 as actual income received for April 2002 ($200 received on April 5, 2002; April 12, 2002; April 19, 2002; and April 26, 2002), and
- $1,000 as actual income received for March 2002 ($200 received on March 1, 2002; March 8, 2002; March 15, 2002; March 22, 2002; and March 29, 2002).

Ex. 2: Applicant applies for retroactive Medi-Cal on May 24, 2002. Applicant states on the MC 210 they are paid $500 every other Friday (bi-weekly) and provides one pay stub received on May 10, 2002 as income verification. Worker determines current month income and projects future month income from pay stub provided.

Applicant applies for retroactive Medi-Cal for the three months prior to date of application and completes the MC 210 A. Applicant indicates "no change"

to income for April 2002. However, due to reduced hours, applicant indicates different income amounts for February and March 2002.

- Based on the single pay stub provided, the worker determines $1,000 as actual income received for the retroactive month of April 2002 ($500 received on April 12, 2002 and April 26, 2002).

- Worker requests applicant to provide income verification for retroactive months of February and March 2002. Applicant provides one pay stub received on March 1, 2002 for $300 as income verification and states that income is consistent for both February and March. Worker determines $600 as actual income received for February 2002 ($300 received February 1, 2002 and February 15, 2002) and $900 as actual income received for March 2002 ($300 received March 1, 2002, March 15, 2002, and March 29, 2002).

Ex. 3: Applicant applies for Medi-Cal on June 1, 2002. Applicant states on the MC 210 they are self-employed and provides a copy of their 2000 'Schedule C' Federal Income Tax Form as income verification. Worker determines applicant's net monthly income to be $1,500 based on current Medi-Cal methodology used to calculate self-employment income (See MPG 10-5-5).
Applicant applies for retroactive Medi-Cal for the month of March 2002 and indicates "no change" to income on MC 210 A. Since the worker has already determined the applicant's net monthly income to be $1,500 based on the self-employment income calculated at initial application, this income is also used for the retroactive months. Therefore, the worker uses $1,500 as actual income received for March 2002.

ACWDL 02-43

c) Determine eligibility and open a retroactive Medi-Cal case. Using Aid Codes RM-1 or RM-2.

d) Compute the share-of-cost (SOC) by completing a budget worksheet Form 14-29 DSS.

2) Granted Procedures

When a beneficiary requests retroactive Medi-Cal after a case has been assigned to a granted worker, the CalWORKs or Medi-Cal granted worker will:

a) Have the beneficiary complete an MC 210A for the retroactive months; and

b) Attach the MC 210A to the active case file and refers the case to intake via the granted supervisor.

E. Previous Denial for Month(s) of Request

The application for retroactive Medi-Cal will be denied when the applicant was previously denied for the requested month(s), unless the application was denied due to:

1) An erroneous denial; or

2) The applicant's failure to cooperate, when the failure to cooperate was due to circumstances beyond the control of the applicant.

F. Processing of Retro Medi-Cal Requests for SSI Recipients

Title 22, California Code of Regulations, Section 50148 states that a request for retroactive Medi-Cal may be made "in conjunction with, or after, application for public assistance or Medi-Cal". An application for "public assistance" includes an application for SSI/SSP benefits. ACWDL 95-51

Based on this regulation the month of application is established along with the SSI/SSP application, for retroactive Medi-Cal purposes, even if aid (in this case, SSI/SSP) is never approved for the application month. The approval of SSI/SSP benefits is not necessary for the determination of the three month retroactive Medi-Cal eligibility, as in any Medi-Cal only application.

Three forms of retro Medi-Cal may be processed by districts:

1) The first, and most common, would be an SSI recipient requesting Medi-Cal coverage back to the month of SSI approval which may be several months prior to the request. This kind of request should be made within six months of the decision or four months from the date of the first SDX update. Since the State cannot establish eligibility in MEDS for SSI recipients prior to their initial approval action, district staff must do the following:

   a) Obtain a verification from Social Security Administration (SSA) indicating the person's SSI/SSP date of eligibility and a request for Medi-Cal coverage for that period of time,

   b) Attach the SSA verification to a 14-28 with the appropriate section completed and submit them to the district MEDS operator to establish eligibility for that period. If the Benefit Identification Card (BIC) has not been received by the client and an immediate need situation occurs, an immediate need paper card may be issued.

   c) Issue an MC 180 **Letter of Authorization** (LOA) if the retro period is over one year. Refer to MPG Article 14, Section 2, Item 7 for details of issuing a LOA.

2) The second form of retro application occurs when an individual is approved SSI with an effective date after the date of SSI application. It is possible that the individual was not financially eligible for SSI during the month of application. The worker

needs to determine if the individual was otherwise eligible. The SSI referral/notice or other verification of entitlement may show a disability onset date prior to the SSI effective date. If determined disabled or there is other linkage in the retro period, the individual would then be eligible if otherwise eligible for Medi-Cal (i.e., residence, property, etc.).

3) The third form of retro application is to request Medi-Cal for the normal three month retro period. If an individual is approved (or denied) SSI, and requests Medi-Cal for the three months immediately preceding the month of SSI application, the worker must obtain verification of the date of the SSI application. Such verification may be an award/denial letter from SSA indicating the date of application and date of approval/denial, or a copy of the individual's original SSI application form, etc. This type of request may require the worker to submit a disability referral to the Disability Evaluation Division (DED) if no other Medi-Cal linkage exists.

Questions and Answers

Q. 1: An individual's SSI/SSP is filed and approved in April 1994. He submits a written request to the County in January 1995 for retro Medi-Cal for January through March, 1994. Can he get retro Medi-Cal for these months? ACWDL 95-51 & 95-81

A. 1: Yes, January through March 1994 are the three months immediately preceding his SSI month of application. If otherwise eligible, he may receive retroactive Medi-Cal for these months.

If the required Medi-Cal linkage is disability and the individual is not receiving or approved for Social Security (Title II) disability benefits for the period in question, a full disability packet to the Disability Evaluation Division (SP-DED) will be necessary to determine whether he meets the disability requirements for the retro months. If SP-DED approves disability from January 1994, and he is otherwise eligible, he is entitled to Medi-Cal for the retro months.

Q. 2: An individual's SSI/SSP application is approved April 1994. He submits a written request to the County in February 1995 for retroactive Medi-Cal for the months of January through March 1994. Can he get retro Medi-Cal for these months?

A. 2: He can only get retro benefits for February and March 1994. MEM Section 50148 states that an application for retro Medi-Cal coverage must be submitted within one year of the month for which retro coverage is requested. It is now too late to be found eligible for January 1994 since it exceeds the one year period. The procedures are the same as discussed in Answer 1.

Q. 3: An individual submits a written request for retro Medi-Cal in April 1995, for April through June 1994. She applied for SSI in July 1994 but was denied. Can she get retro Medi-Cal for those months?

A. 3: The individual must verify that she made an application for SSI in July 1994. Once that is verified the worker must determine if she would have been

eligible for one of the Medi-Cal programs listed in MPG Article 5, Section 1. If otherwise eligible she may receive retro Medi-Cal for those months.

If she is applying on the basis of disability, the worker should check the "SSA Client Referral Chart" in Article 5, Section 4, Appendix A2 to determine whether a disability packet should be sent to SP-DED, as there are specific situations where SP-DED cannot make an independent decision on a previously denied SSA claim. If SP-DED is sent a full disability packet for an independent decision and determines that she is disabled from April 1994, and she is otherwise eligible, the worker can approve Medi-Cal for the retro months.

Q. 4: An individual applies for SSI/SSP in January 1995, but is denied in February. She applies for Medi-Cal in March. The county denies her Medi-Cal application because the "SSA Client Referral Chart" shows that SSA has jurisdiction over the claim. However, SSA subsequently approves her SSI/SSP claim in August 1995 with an onset date of January 1995. She informs the county that she still needs retro Medi-Cal for November and December 1994. What action should the worker take?

A. 4: If she is applying on the basis of disability, the worker needs to send a full disability packet, including the SSA award letter to SP-DED. If SP-DED sets the onset date to November 1994, the worker can rescind the original Medi-Cal denial and approve retro Medi-Cal, if she is otherwise eligible.

Q. 5: An individual applies for SSI/SSP based on disability in July 1995 and is approved by SSA with a July 1995 disability onset date. However, SSA found that he had excess income for July and August, so the effective date of his

SSI/SSP eligibility is September 1995. He then applies for Medi-Cal stating he needs help with unpaid medical bills from April 1995. What action should the worker take?

A. 5: Although the client was technically denied by SSA for July and August 1995 on the basis of excess income, since there is verification of a disability onset date of July 1995, he would be eligible for those two months if he was otherwise eligible for Medi-Cal. The worker should send a full disability packet to SP-DED requesting a retro onset evaluation for the months of April through June 1995. If SP-DED determines that he meets the disability criteria from April 1995 forward, and he is otherwise eligible, the worker can approve retro Medi-Cal effective April 1995.

8. FACE-TO-FACE INTERVIEW

A face-to-face interview with the applicant or person completing the Statement of Facts is no longer required as part of the application process, except as noted in MPG Article 4, Section 6. MEM 50157

9. APPLICANT RESPONSIBILITIES

Applicants or authorized representatives are responsible for providing essential verifications and reporting certain changes in a timely manner. All applicants or authorized representatives are required to: ACWDL 91-98

A. Complete all documents required in the application process or in the determination of continuing eligibility;

B. Provide all verifications requested by the worker needed to determine eligibility and share-of-cost, as specified in MPG Article 4, Section 7;

C. Report all facts that pertain to the determination of eligibility and the share-of-cost;

D. Report within 10 days any changes in income, assets or living situation which pertain to the determination of eligibility or share-of-cost;

E. Cooperate fully in any investigation required for quality control;

F. Report and utilize other health coverage available to the individual or family group;

G. Promptly notify the current worker of any changes in residence from one county to another within the state and apply for a redetermination of eligibility in the new county of residence. ICT procedures are described in MPG Article 3, Section 2.

H. Complete all the forms necessary to process a medical support referral to the Family Support Division of the District Attorney's office.

I. Cooperate with District Attorney's office with the Medical Support Enforcement Program.

10. ELIGIBILITY DETERMINATION

The applicant's Medi-Cal eligibility and share-of-cost determination is made after the applicant has applied, completed the Statement of Facts, and provided all essential information and verifications. The eligibility determination is considered complete on the date the Notice of Action is mailed to the applicant. MEM 50173

A. Promptness Requirements

The determination of eligibility and share-of-cost is completed as quickly as possible but not later than: MEM 50177

1) Forty-five days following the date the application, reapplication or request for restoration is filed; or

2) Sixty days following the date the application, reapplication or request for restoration is filed when eligibility depends on establishing disability or blindness.

B. Extending the Eligibility Determination Deadlines

The 45 or 60-day periods may be extended when:

1) The applicant has good cause and was unable to return the completed Statement of Facts, Supplement to Statement of Facts for retroactive coverage or necessary verifications in time for the worker to meet the promptness requirement.

   a) Good Cause Criteria

      Good cause in this situation includes but is not limited to:

      (1) Physical or mental illness or incapacity of the applicant/authorized representative which prevents the return of the required information.

      (2) A level of literacy of the applicant/authorized representative which, in conjunction with other social and language barriers, prevents the applicant/authorized representative from meeting the established due date.

2) There has been a delay in the receipt of information necessary to determine eligibility and the delay is beyond the control of either the applicant or the worker.

3) The applicant's guardian or other person acting in the applicant's behalf has failed to provide the essential information requested by the worker. The extended eligibility determination period may not exceed 3 months from the date of application in this situation.

4) The applicant demonstrated good faith effort and was granted reasonable opportunity to provide evidence of citizenship and identity. ACWDL 07-12

When the eligibility determination deadline is extended, the worker must document the reasons for the extended deadline in the case narrative.

11. DENIAL OR WITHDRAWAL OF APPLICATION

MPG Article 4, Section 13, addresses situations in which an application for Medi-Cal may be denied or withdrawn. Prior to the denial of the application, the worker will evaluate the applicant's potential eligibility for other programs and determines eligibility for any other program(s) for which the applicant appears eligible and desires assistance as required by MPG Article 4, Section 2.4. MEM 50180

12. REFERRAL FOR SOCIAL SERVICES

The applicant/beneficiary's need for social services is evaluated by the worker as part of the application and redetermination process. When the applicant/beneficiary has a need for social services that cannot be evaluated by the worker or other government agency, the applicant/beneficiary is referred to the contract social worker using the referral procedures for the district office in which the case is being processed. The worker completes the appropriate MEM 50184

"Referral to Contract Social Worker" form for his/her district office, including the following information:

A. Date, client name, date of birth (DOB), address, worker name and phone number;

B. "Reason for referral"; and

C. "Referred to." The worker checks whether the client is being referred to the contract social worker's agency or directly to the contract social worker on duty in the district office on that day.

13. ADDING NEWBORNS

An application form is never required to add an infant to a Medi-Cal case whether or not the infant is deemed eligible. ACWDL 03-49

A. Deemed Eligibility Rules

ACWDL 91-66

No forms of any kind are needed to add a newborn to the Medi-Cal case during the newborn's first year if the following conditions are met:

1) mother received Medi-Cal (zero SOC or where she has met her SOC) at the time of birth,

2) the infant lived with mother at birth and the infant and mother continue to live together, and

3) the mother remains eligible for Medi-Cal or would remain eligible if she were still pregnant.

Infants may be evaluated for Deemed Eligibility at any time during their first year and if determined to be qualified, the worker shall immediately activate Medi-Cal for the child. The infant is "deemed eligible" for one year from the date of birth as long as the required conditions continue to be met. An application is not needed until the child turns one. See MPG 5-15 for more information on Deemed Eligibility. Infants who are deemed eligible must be added to the case within 10 calendar days of receiving the notification. The exception to this is when there is not an active case and additional information is needed. In this situation, the infant must be added within 45 days.

B. Infants Not Qualified for Deemed Eligibility

ACWDL 03-49

Infants who are not deemed eligible (see MPG 5-15) must have an application for a SSN and a statement of citizenship/alien status completed in order to add them to the case.

C. Mother of Newborn Not in the Home

When the mother of the newborn leaves the home and the infant is being cared for by a caretaker relative, a statement of citizenship/alien status and application for SSN must be completed in order to add the newborn to the case.

14. MEDI-CAL REQUESTS FROM OTHER PUBLIC ASSISTANCE (PA) PROGRAM RECIPIENTS

ACWDL 01-36

Workers shall complete an *ex parte* review as outlined in Article 4, Section 7, Item 9.B, whenever they receive requests for Medi-Cal from persons on Other Public Assistance (PA) programs (CalWORKs, Food Stamps, CAPI, General Relief, etc.). The statement of facts from the PA case record is to be used as the statement of facts for the Medi-Cal request. Workers must not surpass the 45-day timeframe for processing applications while obtaining information/verifications from the Other PA case records. As with other applications for Medi-Cal, property limits must be met in the month of application. The property determination will be valid for twelve months or until there is an eligibility review due to a change of family circumstances. The Medi-Cal applicant's signature must be on the statement of facts. It is not necessary for the applicant to sign the SAWS 1. Workers can complete and sign the SAWS 1 using the date that Medi-Cal was requested. The redetermination date will be twelve months from the date of the SAWS 1.

15. MAIL-IN APPLICATIONS

A. All Medi-Cal applicants now have the option of returning their forms and completing the application process by mail. This includes applicants at clinics, outstation sites and those who apply through the Perinatal Care Network. For exceptions to the mail-in option see Article 4, Section 6.

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1) Mail-In Application Packets

Individuals may pick-up application packets in person at FRCs or receive applications by mail by calling PAI at (866) 262-9881. In order to facilitate the application process and to remove barriers to access, packets given to Medi-Cal applicants are to be kept as simple as possible. Forms that the applicant must complete are to be grouped together and separated from forms that are information only in each packet. When an application is requested by mail, packets are to be divided into two groups.

- One simplified general packet is to be given to all Medi-Cal mail-in applicants.
- A supplemental group of forms and brochures is to be mailed once the statement of facts is returned and the worker evaluates the specific needs of the applicant.

Note: If an applicant goes to a FRC to pick up an application, the FRC may screen the applicant at that time and provide any additional forms that may be required.

a) Contents of the Basic Packet

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- 14-68 HHSA (3/02) or 14-68 S HHSA (3/02)-Mail-In Cover Letter
- HHSA: HSD 7-Health Care Options
- Pub 68-Medi-Cal What It Means To You (rev 2/01)
- 16-69 HHSA-Public Charge flyer
- MC 008-Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal
- MC 210 (rev 8/01)-Revised Medi-Cal Application
- MC 219-Important Information for Persons Requesting Medi-Cal
- 20-46-Language Needs Determination
- MC 13-Statement of Citizenship and Alienage
- Pub 13-Your Rights
- MC 007-Medi-Cal Information Notice
- Mental Health Managed Care Notice
- DHCS 0001 – U.S. Citizens and Nationals Applying for Medi-Cal Must Show Proof of Citizenship and Identity

ACWDL 07-12

b) Contents of Supplemental Packet

- Supplemental Packet Mail-In Medi-Cal Application Coversheet (rev 12/01)
- 16-64-Would You like To Register To Vote
- 20-44-Civil Rights Information
- Notice to Medi-Cal Beneficiaries About Mental Health Benefits
- MC 325-TMC Flyer (rev per SN 01-19)
- Any additional forms required for the specific case situation such as:
    - When children apply:
        - DHS PHE-P265-CHDP brochure when children are applying for Medi-Cal

- Child Support forms when there is an absent/unmarried parent (CA 2.1, CA 2.1Q, Pub 160)
- HHSA: IZ71-Baby Shots Schedule
- 14-59 HHAS-Motor Vehicle Property Sheet for potential Section 1931(b) cases
- MC 003-Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Brochure

- Other situations:

  - DHS 6155-Other Health Care Coverage Questionnaire
  - 14-47 HHSA-DHS 6155 Attachment
  - DHS 7077-Notice Regarding Standards for Medi-Cal Eligibility when an applicant is in Long Term Care
  - DHS 7077 A-Notice Regarding Transfer of a Home for Both a Married and an Unmarried Applicant/Beneficiary when an ABD individual is not in Long Term Care — ACWDL 02-60
  - MC 210 supplemental forms (MC 210 PS, MC 210 S-I, MC 210 S-W, etc.) — ACWDL 03-11
  - Women, Infants and Children (WIC) Brochure-when pregnant women and/or children apply.

2) General Procedure for a Request for Medi-Cal Application — MEM 50159, MEM 50161, County Policy

The procedures described below are to be used whether the request is by phone or in person at a FRC.

a) An applicant who applies by mail is not required to attend a Health Care Options (HCO) or Rights and Responsibilities presentation. He/she will receive a HCO packet by mail. However, the applicant may attend a HCO presentation if he/she chooses. Workers are to encourage applicants to attend as orientations are highly beneficial and help them make an informed choice in health coverage. Refer interested applicants to the HCO enrollment counselor. The enrollment counselors' phone numbers and other HCO information are included in the application packet.

b) At the time a person requests an application, explain to the applicant that he/she can apply for Medi-Cal as a mail-in or attend a face-to-face interview. If he/she wants to apply for Food Stamps in addition to Medi-Cal or needs expedited services, explain to the applicant that a face-to-face interview is required for the Food Stamp application. A face-to-face interview is also advisable for the request for expedited services. He/she may want to schedule a face-to-face for the Medi-Cal application along with the Food Stamp application, or to speed up their request for expedited services.

c) Advise the applicant that there is a different statement of facts for Food Stamps and a requirement for a face-to-face interview. Encourage the

applicant to apply for Medi-Cal in person to streamline a combined application. Explain the advantages of the IAR interview to the applicant for those FRCs that have IAR. However, the applicant may still apply for Medi-Cal by mail if he/she so chooses.

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d) FRCs should assign the duty of explaining options to the applicant to a specific person/function so that this activity is not overlooked. MEM 50161 County Policy

3) Application is Requested by Phone

a) Those FRCs with a phone-in application system may continue to use that system to mail application packets in addition to the procedures described in this section for processing the SAWS 1 forms. They do not need to refer applicants to PAI.

b) For those FRCs with no phone-on system, refer the applicant who chooses to be mailed an application packet to PAI.

c) PAI will clear all people requesting an application packet for an active Medi-Cal case. If none exists, PAI will mail an application packet.

d) If an HF/mail-in application (MC 321 HFP) is mailed, the following procedures in this section will be disregarded.

e) PAI will complete a SAWS 1 for each packet mailed. The SAWS 1 will be signed and dated the date the application packet was requested. PAI will also complete the date received using the date indicated above, in the "County Use" section. PAI will batch and forward the SAWS 1 forms on a daily basis to the appropriate FRC.

f) A SAWS 1 is not required with the MC 210 (rev 8/01). Therefore, it is not necessary that the SAWS 1 form forwarded by PAI include the applicant signature. If the applicant should come into the office at a later date, he/she may be asked to sign the SAWS 1.

g) PAI will enter the date of birth for the person requesting Medi-Cal on the SAWS 1 in box #2 under the Social Security number. PAI will also ask how many family members want Medi-Cal. PAI will include the appropriate number of MC 13s in the packet and mail it the same day as the request.

h) The return envelope included with the application packet is addressed to PAI. When received from the applicant, PAI will log in the packet and forward to the appropriate FRC on the same day. Unless the FRC instructs PAI differently, the mail-in packets will be forwarded to the designated HF/mail-in application contact.

i) The day the FRC receives the SAWS 1, the Mail-In Liaison (or other County Policy

appropriate staff appointed by the FRC) is to log the application in with the date of application and the date of receipt.

j) The application must be open pended with the FRC's generic Mail-In worker number. This number is to be #M00, where # is the FRC's designator (for example: Lemon Grove's would be GM00). The worker name shall be "Mail-In Staff." The phone number of the Mail-In Liaison (or other appropriate staff appointed by the FRC) must be listed and be available to answer questions from applicants regarding the mail-in process. The application date is the date that PAI received the request for application, which PAI enters on the SAWS 1. MEM 50159 MEM 50161 County Policy

k) The person who open pends the application must also order the Automated Letter (AL) 746. AL 746 reminds the applicant of the requirements to complete the application process. The AL is considered the first request for information and must be mailed without delay.

l) Open pended cases will be maintained in a central bank in Clerical.

m) A mail-in application is to be treated the same as a face-to-face appointment for the purpose of scheduling Intakes and assigning to workers. Requests for Medi-Cal by pregnant women are considered an Immediate Need.

4) An Applicant Requests a Medi-Cal Application at a FRC or Outstation Site

a) An applicant may pick up an application packet from any FRC.

b) Give the applicant an application packet. The packet must contain the same forms described in the application packet in 3.B above and may include any additional forms that the FRC normally includes in its packets appropriate for the mail-in process. The MC 321 HFP may be given to children and/or pregnant women-only applicants in lieu of the application packet.

c) If the applicant chooses to attend a face-to-face interview, schedule the appointment according to FRC/outstation procedures. If the applicant chooses to mail-in the application packet, ask the applicant to complete a SAWS 1, keep the original copy or forward to the correct FRC for that address, include a return envelope addressed to the FRC that will process the application, then follow the procedures described below. **Exception**: **Outstations will process the SAWS 1 requests they receive.** County Policy

5) Informing Notice, 09-83 HHSA, Received from a Food Stamp Recipient ACWDL 03-40

A Food Stamp recipient may request a Medi-Cal evaluation by completing and returning the Informing Notice, 09-83. The Medi-Cal application will be processed as a mail-in application except for the following:

a) Forms

- The signed and dated Informing Notice will be used as a SAWS 1 initiating the request for Medi-Cal and the date of application will be the date the Informing Notice is received by the County.
- The DFA 285-A1 and DFA 285-A2 will be used as the Statement of Facts for the Medi-Cal application as long as the DFA 285-A2 is dated within the last 12 months and signed by the Medi-Cal applicant or the applicant's spouse or parent of a minor child. ACWDL 03-40
- There is no requirement to mail out the MC 219 because the Informing Notice includes the Rights and Responsibilities.
- An MC 13 will be requested for each individual applying for Medi-Cal. (Workers will use verification of legal resident status from the Food Stamp case before requesting it from the applicant.)
- Based on review of the Food Stamp Statement of Facts, staff will mail out all other necessary forms including, but not limited to, the Disability and Adult Programs Division (DAPD) packet, the Other Health Care Coverage form and the Child Support packet.

b) Verifications

- The most current verifications of income from the Food Stamp case will be used in the Medi-Cal determination as long as there is no reported change.

- The most current verification of property from the Food Stamp case will be used as long as it is dated the month of the Medi-Cal application or not subject to change.
- All other verifications available from the Food Stamp case will be used in the Medi-Cal determination.

c) Referral to Healthy Families Program – A referral to the Healthy Families Program will be made following procedures in 4-2-15 if:

- The applicant has given permission to forward the information in the Food Stamp case to the HF Program for a determination;
- The result of the Medi-Cal determination is ineligibility or a share-of-cost for children under 19; and
- The children are potentially eligible to HF.

6) NSLP/Medi-Cal Application Processing ACWDLs 03-35, 03-38

The NSLP application will be used as a Medi-Cal mail-in application and statement of facts when a child is determined eligible to free lunch and the parent/caretaker gives consent for the sharing of information. This does not allow sharing of case information with school staff.

a) Express Enrollment, Aid Code 7T – A child meeting Express Enrollment eligibility criteria will be activated in temporary and immediate Medi-Cal. The temporary Medi-Cal begins with the date the school determines the child Express Enrollment eligible and continues until the on-going Medi-Cal evaluation is completed. See Appendix 4-2-B for instructions to discontinue aid code 7T if child is denied on-going Medi-Cal.

b) Application Date – The Medi-Cal application date is the date the NSLP application is received by the county.

c) Supplemental Application Packet – The following forms will be sent to NSLP/Medi-Cal applicants in order to provide the family with all information currently required for new applicants and to request information, which is necessary to complete an accurate Medi-Cal determination.

- Notice and Supplemental Form for Express Enrollment Applicants (MC 368) – Notifies the family of the child's Express Enrollment status, requests required information and eliminates the need to mail out form MC 13, available in English and Spanish
- Important Information For Medi-Cal Applicants (MC 368 A) – Eliminates the need to mail out form MC 219, available in English and Spanish
- Other Health Care Coverage (DHS 6155)
- Medical Support forms (CW 2.1, CW 2.1Q, Pub 160) – If it can be determined from the NSLP application that deprivation based on absence exists for the child
- Language Needs Determination (20-46) – Not required to be returned
- Health Care Options (HHSA: HSD 7)
- CHDP Informational Publication (DHS PHE-P265)
- Early and Periodic Screening, Diagnosis and Treatment Brochure (MC 003)
- Medi-Cal Brochure (Pub 68).

ACWDLs 03-35, 03-38

d) Declaration of Citizenship/Immigration Status – Citizenship/immigration status will be declared on form MC 368 and eliminates the need for form MC 13. Documentation of satisfactory immigration status must be provided. Workers will follow procedures in MPG Article 7-1-5 when requesting documentation of satisfactory immigration status.

e) California Residency – Proof that the applicant child is eligible to/receiving free lunch through NSLP is sufficient documentation of California residency.

f) Self-Declaration Of Income – Income may be self-declared, with no documentation required, for the purpose of determining eligibility for the applicant child. Documentation will be required when:

- A change is reported during or after the Medi-Cal determination
- IEVS discrepancies need clarification

- Retroactive coverage is requested
- Income was not reported on the NSLP application, or
- Other family members request Medi-Cal.

g) Allowable Income Deductions - $90 standard work deduction is allowed based on self-declared income if income can be verified through IEVS. All other income deductions require documentation.

h) Continuous Eligibility For Children (CEC)/Bridging – A child is not eligible to CEC/Bridging based solely on the receipt of temporary Medi-Cal through aid code 7T. Eligibility to CEC/Bridging requires that children must complete the enrollment process and be determined eligible to no SOC Medi-Cal.

i) Medi-Cal Requested By Other Family Members – Applicants must complete Additional Family Members Requesting Medi-Cal, form MC 321HFP-AP and form MC 322 (non-asset waiver eligibility determinations) when other family members ask to be evaluated for Medi-Cal. Normal documentation will be required. The evaluation of eligibility of other family members will not delay the NSLP child's Medi-Cal eligibility determination under the age appropriate FPL Program.

j) Healthy Families Referral – The NSLP/Medi-Cal application **may not** be referred to the Healthy Families Program for a Healthy Families evaluation. If children are determined potentially eligible to Healthy Families, workers will mail the Healthy Families application, MC 321 HFP, to the parents.

7) Mail-In Application Procedures

a) Follow a fifteen-ten-ten timeline for the client to provide the application packet (this will allow five extra days for applicant to receive the packet from PAI by mail). Day one is the day the SAWS 1 is dated. The date of receipt is the date the application packet is received by the County (either by PAI or the FRC).

b) FRC's are encouraged to attempt a reminder phone contact prior to denial with those families who do not submit the application packet. If the application packet is not received by the 15th day after the application date, clerical will deny the application using the 130 denial code.

c) Upon receipt of the application packet by the FRC, the application is to be assigned to an worker to be processed. The worker shall review the application for completeness and send the appropriate supplemental packet. If additional information is needed for an accurate eligibility determination, the worker shall look for the information/verification contained in open public assistance (PA) case records of the individual and their immediate family members and/or case records that have been closed within the last 45 days. If the necessary information cannot be obtained through available PA case records, the worker shall request this information

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following current policy as outlined in MPG Article 4, Section 14. Current guidelines for application processing, property and income verification have not changed.

d) Once all required steps (as outlined in MPG Article 4, Section 14) have been completed, deny the application if any requested information/ verifications are not received completed, and good cause is not determined. If the applicant has provided a phone number, two phone contacts must be attempted prior to denying the application. Narrate the phone attempt or contact. Note: workers should also utilize any contracted outreach that is set up in their FRC to attempt to obtain the needed verification from the applicant.

e) If the application packet/additional required forms are returned more than ten days after the date of the denial:

(1) Complete a new SAWS 1. The new SAWS 1 date shall be the date the application packet/verifications were received after the denial action. Process the application.

(2) The Intake scheduling person should enter the resubmitted application on the schedule as a new intake.

(3) There is no limit to the number of times a new SAWS 1 may be completed. However, the MC 210 must be dated by the applicant no more than twelve months prior to the application date.

(4) The redetermination date must not be more than twelve months from the client's signature on the statement of facts or SAWS 1 date whichever is earlier.

(5) The information reported on the MC 210 must adequately and accurately reflect the family's or individual's situation in the month of application for the new SAWS 1.

(6) Confirm whether there have been changes in the household that may affect eligibility since the applicant last signed the MC 210 (a phone contact is sufficient). If there were no changes, narrate in the case that no changes occurred. If changes have occurred, any necessary actions must be taken, the MC 210 must be corrected and verification needed to establish eligibility must be in the case file.

(7) The worker shall first seek needed verifications through other PA cases prior to contacting the applicant. If necessary verification is not available through other PA cases, or automated systems, the worker shall then request the information from the applicant.

(8) If the verifications are not received or if they are received incomplete, use the standard ten-ten-ten timeline for providing requested documents as outlined in MPG Article 4, Section 13.

(9) If the application is an MC 321 HFP, use the established procedures as described in MPG, Article 4, Section 20, except that other family members are not required to attend a face-to-face interview. Do not mail the AL 715 when adding other family members unless it is determined that the face-to-face interview is necessary. Use NOA 936 to request additional required forms such as the MC 321 HF-AP and/or verification. MEM 50159 MEM 50161 County Policy

(10) Use Negative Action Code "130" to deny an application if the SAWS 1 was received by the FRC, but the applicant fails to return the application packet within 15 days.

(11) Use Negative Action Code "139" to deny an application if the packet was returned, but verifications are missing and the time line for providing them has passed.

(12) FRCs are to monitor to assure that mail-in applications are processed timely and preference is not given to face-to-face interview intakes.

8) Mail-In Application Tracking

It is necessary to track all cases processed through the mail-in option. At the time they are pended by the FRCs or outstations:

- Cases that are processed as mail-in applications are to be coded by entering a "Z" in the Special Characteristics Box D on the BDLM APPL screen.
- Cases that are processed using the Food Stamp Statement of Facts, based on the receipt of the Informing Notice 09-83, are to be coded by entering an "F" in the Special Characteristics Box D. County Policy

Use the appropriate code regardless of the final outcome of the case, i.e., whether or not a face-to-face interview is scheduled or the case is denied or granted.

9) Assembling the Packets

The responsibility for assembling the packets remains with the FRCs even though PAI will mail the packets for the mail-in process. Each packet should be enclosed in a mailing envelope. Include a return envelope addressed to PAI and marked with an "M". Each FRC will routinely send 100 English packets on a monthly basis to PAI. One hundred (100) Spanish packets will be requested by PAI, when needed, on a rotating basis from each FRC.

16. FORWARDING THE MC 210 OR DFA 285-A1/A2 TO HF

A. Referral to HF Using the MC 210

HF will accept the new MC 210 (rev 8/01) as an application for HF. If this MC 210 was used as the application for Medi-Cal, staff must review question 59 to determine if the applicant has given consent for the application to be forwarded to HF if there is a share of cost (SOC) for any family member potentially eligible to HF. ACWDL 03-05

- If Question 59 has been answered "Yes," they have consented. The application can be forwarded.
- If Question 59 has been answered "No," they have not consented. The application cannot be forwarded. MEM 50159 MEM 50161
- If Question 59 has not been answered, or another form was used as the statement of facts, the worker must attempt to contact the responsible adult. The attempt and response must be narrated in the case file. If consent is given, this also must be documented in the Comments Section of the transmittal form. The responsible adult must be told that their application and information will be forwarded to HF. This consent does not need to be in writing. If consent is not given, the responsible adult is to be told that if they are interested in HF, they must contact HF. County Policy

B. Referral to HF Using the DFA 285-A1/A2 ACWDL 03-40

HF will accept the DFA 285-A1 and A2 as a HF application. The applicant must give permission on the Informing Notice, 09-83, authorizing the County to forward information from the Food Stamp case to the HF program. If the Medi-Cal determination results in ineligibility or share-of-cost for children under 19, the County will complete a referral to HF.

C. Referral Packet

The copy of the MC 210 or DFA 285-A1/A2 must be accompanied by the Medi-Cal/HF Mail-In Application transmittal (MC363). A copy of the Informing Notice, 09-83, must be sent with the DFA 285-A1/A2. A SOC or Federal Poverty Level (FPL) program denial Notice of Action (NOA) will also be included in the referral packet. The NOA shall: ACWDL 03-40

- Not be older than 60 days,
- Identify those family members determined to have a SOC, or denied due to income above the FPL,
- Indicate the total number of persons in the Medi-Cal family budget unit, and
- Clearly and separately identify all income sources and deductions.

If a NOA with the above information is not available, workers may send a copy of the manual budget MC 176, or an automated budget reflected on the SOC or denial NOA. Do not send Sneede allocation budgets.

Note: Workers shall include other relevant documentation (e.g. birth certificates, Immigration and Naturalization Service documents) if available, with the referral to HF.

EXAMPLE OF IDX CMS ELIGIBILITY ENROLLMENT SUMMARY SCREEN

Member: ***Patient Last Name, First Name***

Con	Effective date	Member number	Stat	Mem type	Cont type	PCP/ Site	Subscriber	Employer	Plan
2	Effective: 05/15/2001					Terminated: 11/30/2002			
	(Comment line will appear here only if entries are made)								
	06/01/02 Indiv:	SSN-99-0000	CA	SBS	DSS	161/UNAS Self Group:	ST	2-STANDARD	
	05/16/02 Indiv:	SSN-99-0000	INACT	SBS	DSS	800/UNAS Self Group:	ST	2-STANDARD	
	05/15/02	SSN-99-0000	CA	SBS	ER	161/UNAS Self	ER	1-EMERGENCY	
	05/01/02 Indiv:	SSN-99-0000	INACT	SBS	INA	800/UNAS Self Group:	INAC	8-INACTIVE	
	11/01/01 Indiv:	SSN-99-0000	CA	SBS	DHS	55/NPFHC Self Group:	ST	2-STANDARD	

D. To determine if CMS has been approved, look at the most recent date and stat code (see highlighted example above).

The following stat codes indicate that CMS has been approved.

CA: CMS approved.

A-A: CMS approved and Medi-Cal approved for restricted and limited services.

A-P: CMS approved and Medi-Cal or SSI pending.

A-R: CMS approved three months referred to apply Medi-Cal.

AUG: Urgent Primary Care approved.

AER: Emergency Room approved.

EXPRESS ENROLLMENT AUTOMATION

WORKER ACTION:

- Review file clearance information on MEDS/SCI (INQN, INQP, & INQR screens).

  - o Express Enrollment aid code is 7T
  - o Verify correct CIN #
  - o Birthdate and MEDS ID (SSN, pseudo) on pending case must match existing MEDS record

- Granting actions taken by the county before **or after** MEDS renewal will cause MEDS to automatically terminate the Express Enrollment record at the end of the calendar month in which the approval is posted to MEDS. Eligibility for the month of application and ongoing will be recorded under the county ID on MEDS. Once granted, both the Express Enrollment aid code and the regular Medi-Cal program aid code will show dual eligibility on MEDS for the month of application and ongoing eligibility under the regular Medi-Cal aid code only.

- If denying the application, the worker must submit a 14-28 HHSA MEDS Network On-Line Request form with a MEDS screen print of the Express Enrollment record from INQ1 screen and a copy of the case LMO to MEDS operator with the following information:

  - o 14 digit county ID (using IE as aid code – 37-IE-seven digit county case serial-last digit FBU-person number)
  - o Birth date (must match MEDS)
  - o MEDS ID (SSN or pseudo – must match Express Enrollment {7T aid code} record on MEDS)
  - o CIN #
  - o Application date (must match Express Enrollment record/found on INQP screen)
  - o Application flag (valid county value is P)
  - o Denial date
  - o Denial reason

- Workers will send AL 928-1 to notify the client that temporary Express Enrollment benefits have discontinued, or that temporary Express Enrollment benefits have discontinued and ongoing eligibility has been established under another Medi-Cal program.

- MEDS produces monthly (Renewal) worker alerts to reflect the time an applicant remains in an accelerated enrollment aid codes including Express Enrolled beneficiaries in aid code 7T. San Diego County has chosen to have one of the two optional alerts generated. Message 9546 OVER 2 MONTHS ACCEL ENROLL – APP DETERMINATION OVERDUE is generated at the end of the second and subsequent months when eligibility is continuing into MEDS Renewal month.

  Note: Until Application Tracking is automated, the county must report pending application and denial information manually using on-line MEDS transactions. Staff will be notified via Export Notes when Application Tracking is automated.

MEDS OPERATOR ACTION:

Until application tracking is automated MEDS Operators will process the 14-28 and submit the AP34 on-line transaction to report the denial with the information listed above from the worker.